		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.

IDPH Facility ID Number: 0032276

Facility Name: BOULEVARD CARE CENTER

Address: 3405 S. MICHIGAN AVE. (Number) CHICAGO (City) 60616 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3507813

Date of Initial License for Current Owners: 05/01/87

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,027	2,027	8
9	SNF/PED					9
10	ICF	48,852	518		49,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,852	518	2,027	51,397	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.85%

D. How many bed-hold days during this year were paid by Public Aid?
834 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 2,027

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	146,320	17,583	9,703	173,606		173,606	1,876	175,482			1
2	Food Purchase		174,717		174,717	(16,754)	157,963	(310)	157,653			2
3	Housekeeping	119,705	22,971		142,676		142,676		142,676			3
4	Laundry	54,430	12,798		67,228		67,228		67,228			4
5	Heat and Other Utilities			107,712	107,712		107,712	434	108,146			5
6	Maintenance	40,546	29,680	38,071	108,297		108,297	10,500	118,797			6
7	Other (specify):*			12,899	12,899		12,899		12,899			7
8	**TOTAL General Services**	361,001	257,749	168,385	787,135	(16,754)	770,381	12,500	782,881			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,292,554	49,518	2,592	1,344,664		1,344,664	33,614	1,378,278			10
10a	Therapy	54,967	903	44,321	100,191		100,191	3,173	103,364			10a
11	Activities	65,531	4,092	2,024	71,647		71,647		71,647			11
12	Social Services	71,535		2,956	74,491		74,491		74,491			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,484,587	54,513	51,893	1,590,993		1,590,993	36,787	1,627,780			16
	C. General Administration											
17	Administrative	130,177		144,000	274,177		274,177	(88,602)	185,575			17
18	Directors Fees											18
19	Professional Services			226,267	226,267		226,267	(172,194)	54,073			19
20	Dues, Fees, Subscriptions & Promotions			16,943	16,943		16,943	206	17,149			20
21	Clerical & General Office Expenses	97,436	10,998	160,372	268,806		268,806	(67,540)	201,266			21
22	Employee Benefits & Payroll Taxes			348,626	348,626	16,754	365,380		365,380			22
23	Inservice Training & Education			740	740		740	1,049	1,789			23
24	Travel and Seminar							420	420			24
25	Other Admin. Staff Transportation			86	86		86	2,963	3,049			25
26	Insurance-Prop.Liab.Malpractice			122,737	122,737		122,737	4,458	127,195			26
27	Other (specify):*							41,171	41,171			27
28	**TOTAL General Administration**	227,613	10,998	1,019,771	1,258,382	16,754	1,275,136	(278,069)	997,067			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,073,201	323,260	1,240,049	3,636,510		3,636,510	(228,782)	3,407,728			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BOULEVARD CARE CENTER #0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			63,289	63,289		63,289	99,212	162,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			113,643	113,643		113,643	441,303	554,946			32
33	Real Estate Taxes			163,589	163,589		163,589		163,589			33
34	Rent-Facility & Grounds			565,312	565,312		565,312	(556,480)	8,832			34
35	Rent-Equipment & Vehicles			28,237	28,237		28,237	(3,497)	24,740			35
36	Other (specify):*											36
37	**TOTAL Ownership**			934,070	934,070		934,070	(19,462)	914,608			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,876	84,007	119,883		119,883	(11,434)	108,449			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		35,876	168,870	204,746		204,746	(11,434)	193,312			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,073,201	359,136	2,342,989	4,775,326		4,775,326	(259,678)	4,515,648			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(25,455)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(310)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(60,551)	21		18
19	Entertainment		20		19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,980)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(1,181)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,877)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(169,801)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (169,801)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (259,678)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BOULEVARD CARE CENTER

ID# 0032276

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (1,181)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,181)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	1,876	0	0	0	0	0	0	0	0	0	1,876	1
2	Food Purchase	(310)	0	0	0	0	0	0	0	0	0	0	(310)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	434	0	0	0	0	0	0	0	0	0	434	5
6	Maintenance	(1,181)	11,681	0	0	0	0	0	0	0	0	0	10,500	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,491)	13,991	0	0	0	0	0	0	0	0	0	12,500	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	33,614	0	0	0	0	0	0	0	0	0	33,614	10
10a	Therapy	0	9,205	0	(6,032)	0	0	0	0	0	0	0	3,173	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	42,819	0	(6,032)	0	0	0	0	0	0	0	36,787	16
	C. General Administration													
17	Administrative	0	(144,000)	55,398	0	0	0	0	0	0	0	0	(88,602)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(180,000)	7,806	0	0	0	0	0	0	0	0	(172,194)	19
20	Fees, Subscriptions & Promotions	(2,380)	0	2,586	0	0	0	0	0	0	0	0	206	20
21	Clerical & General Office Expenses	(60,551)	(93,000)	86,011	0	0	0	0	0	0	0	0	(67,540)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,049	0	0	0	0	0	0	0	0	1,049	23
24	Travel and Seminar	0	0	420	0	0	0	0	0	0	0	0	420	24
25	Other Admin. Staff Transportation	0	0	2,963	0	0	0	0	0	0	0	0	2,963	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,458	0	0	0	0	0	0	0	0	4,458	26
27	Other (specify):*	0	0	41,171	0	0	0	0	0	0	0	0	41,171	27
28	**TOTAL General Administration**	(62,931)	(417,000)	201,862	0	0	0	0	0	0	0	0	(278,069)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(64,422)	(360,190)	201,862	(6,032)	0	0	0	0	0	0	0	(228,782)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number BOULEVARD CARE CENTER **#** 0032276 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(25,455)	0	124,667	0	0	0	0	0	0	0	0	99,212	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	441,303	0	0	0	0	0	0	0	0	441,303	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(556,480)	0	0	0	0	0	0	0	0	(556,480)	34
35	Rent-Equipment & Vehicles	0	(11,679)	8,182	0	0	0	0	0	0	0	0	(3,497)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(25,455)	(11,679)	17,672	0	0	0	0	0	0	0	0	(19,462)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(11,434)	0	0	0	0	0	0	0	(11,434)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(11,434)	0	0	0	0	0	0	0	(11,434)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(89,877)	(371,869)	219,534	(17,466)	0	0	0	0	0	0	0	(259,678)	45

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE				CAREPLUS MGMT.	NILES	MGMT/CLERICAL
				CAREPLUS REHAB	NILES	THERAPY
				BOULEVARD		
				PROPERTY, LLC	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY CONSULT. FEES	$ 6,600	CAREPLUS MANAGEMENT, INC.		$	$ (6,600)	1
2	V	17	MANAGEMENT FEES	144,000	" "			(144,000)	2
3	V	19	ADMIN. CONSULT. FEES	168,000	" "			(168,000)	3
4	V	19	DATA PROCESS FEES	12,000	" "			(12,000)	4
5	V	21	CLERICAL FEES	93,000	" "			(93,000)	5
6	V	35	COMPUTER LEASE	11,679	" "			(11,679)	6
7	V	1	DIETARY SALARIES		" "		8,476	8,476	7
8	V	5	ELECTRICITY		" "		434	434	8
9	V	6	MAINT & REPAIRS		" "		1,031	1,031	9
10	V	6	MAINTENANCE SALARIES		" "		10,650	10,650	10
11	V	10	NURSING SALARIES		" "		33,614	33,614	11
12	V	10a	THERAPY SUPPLIES SERVICE		" "		299	299	12
13	V	10a	THERAPY SALARIES		" "		8,906	8,906	13
14	Total			$ 435,279			$ 63,410	$ * (371,869)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 565,312	BOULEVARD PROPERTY, LLC		$	$ (565,312)	15
16	V	30	SL DEPRECIATION				110,657	110,657	16
17	V	32	INTEREST				406,930	406,930	17
18	V								18
19	V								19
20	V	17	ADMIN. SALARIES		CAREPLUS MGMT. INC.		55,398	55,398	20
21	V	19	PROFESSIONAL FEES		" "		7,806	7,806	21
22	V	20	ADVERTISING		" "		2,586	2,586	22
23	V	21	TOTAL OFFICE		" "		21,573	21,573	23
24	V	21	CLERICAL SALARIES		" "		64,438	64,438	24
25	V	23	SEMINARS		" "		1,049	1,049	25
26	V	24	TRAVEL		" "		420	420	26
27	V	25	TRANSPORTATION		" "		2,963	2,963	27
28	V	26	INSURANCE		" "		4,458	4,458	28
29	V	27	EMPLOYEE BENEFITS		" "		41,171	41,171	29
30	V	30	DEPRECIATION (SL)		" "		14,010	14,010	30
31	V	32	INTEREST		" "		34,373	34,373	31
32	V	34	OFFICE RENT		" "		8,832	8,832	32
33	V	35	EQUIPMENT RENT		" "		8,182	8,182	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 565,312			$ 784,846	$ * 219,534	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	$ 44,320	CAREPLUS REHABILITATIVE SERVICES		$ 38,288	$ (6,032)	15
16	V	39	ANCILLARY THERAPY	84,006			72,572	(11,434)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,326			$ 110,860	$ * (17,466)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATION:								$		1
2	SHERWIN RAY	PRESIDENT	ADMINISTRAT.		SEE ATTACHED	5.3	51.39	SALARY	16,401	17-7	2
3			FINANCE		SCHEDULE						3
4			BANKING								4
5	JAKOB BAKST	DIR OPERATIONS	FINANCE			5.3	51.39	SALARY	16,401	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 32,802		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	459,177	9	$ 75,722	$ 75,722	51,397	$ 8,476	1
2	5	ELECTRICITY	CENSUS DAYS	579,760	13	4,894		51,397	434	2
3	6	MAINT & REPAIRS	CENSUS DAYS	579,760	13	11,630		51,397	1,031	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	579,760	13	120,135	120,135	51,397	10,650	4
5	10	NURSING SALARIES	CENSUS DAYS	579,760	13	379,168	379,168	51,397	33,614	5
6	10a	THERAPY SUPPLIES SERVICE	CENSUS DAYS	579,760	13	3,372		51,397	299	6
7	10a	THERAPY SALARIES	CENSUS DAYS	579,760	13	100,459	100,459	51,397	8,906	7
8	17	ADMIN. SALARIES	CENSUS DAYS	579,760	13	624,886	624,886	51,397	55,398	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	579,760	13	88,050		51,397	7,806	9
10	20	ADVERTISING	CENSUS DAYS	579,760	13	29,166		51,397	2,586	10
11	21	TOTAL OFFICE	CENSUS DAYS	579,760	13	243,348		51,397	21,573	11
12	21	CLERICAL SALARIES	CENSUS DAYS	579,760	13	726,859	726,859	51,397	64,438	12
13	23	SEMINARS	CENSUS DAYS	579,760	13	11,834		51,397	1,049	13
14	24	TRAVEL	CENSUS DAYS	579,760	13	4,741		51,397	420	14
15	25	TRANSPORTATION	CENSUS DAYS	579,760	13	33,425		51,397	2,963	15
16	26	INSURANCE	CENSUS DAYS	579,760	13	50,288		51,397	4,458	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	579,760	13	464,414		51,397	41,171	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	579,760	13	158,032		51,397	14,010	18
19	32	INTEREST	CENSUS DAYS	579,760	13	387,734		51,397	34,373	19
20	34	OFFICE RENT	CENSUS DAYS	579,760	13	99,626		51,397	8,832	20
21	35	EQUIPMENT RENT	CENSUS DAYS	579,760	13	92,291		51,397	8,182	21
22										22
23										23
24										24
25	TOTALS					$ 3,710,074	$ 2,027,229		$ 330,669	25

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD PROPERTY, LLC
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	SL DEPRECIATION	DIRECT COST	1	1	$	$	1	$	1
2	32	INTEREST	DIRECT COST	1	1			1		2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: BOULEVARD PROPERTY, LLC						$	$			$	1
2	PACIFIC MUTUAL		X	MORTGAGE	$38,703.00	12/95	4,657,452	4,166,273	01/08	0.0888	374,356	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER 12 YEARS		116,756	47,931	01/08		9,730	3
4	CIB BANK		X	CAPITAL IMPROVEMENT	$7,582.96	02/01	360,000	238,964	02/06	PRIME+	22,484	4
5	LOAN COSTS		X	LOAN COSTS	W/O OVER 5 YEARS		1,800	1,140	02/06		360	5
	Working Capital											
6	CAREPLUS MGMT, INC.	X		WORKING CAPITAL	DEMAND	04/95	450,000	1,800,000		PRIME+	109,793	6
7	IMPERIAL A. I. CREDIT		X	INSURANCE FINANCE							3,850	7
8	CAREPLUS MGMT ALLOCATION										34,373	8
9	TOTAL Facility Related				$46,285.96		$ 5,586,008	$ 6,254,308			$ 554,946	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,586,008	$ 6,254,308			$ 554,946	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 157,010	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 159,502	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,492	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 161,097	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 163,589	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	182,228	8
	1998	185,463	9
	1999	184,219	10
	2000	155,459	11
	2001	159,502	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BOULEVARD CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032276

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-34-119-001-0000	NURSING HOME	$ 47,181.11	$ 47,181.11
2.	17-34-119-002-0000	NURSING HOME	$ 7,974.68	$ 7,974.68
3.	17-34-119-003-0000	NURSING HOME	$ 78,747.70	$ 78,747.70
4.	17-34-119-004-0000	NURSING HOME	$ 7,640.00	$ 7,640.00
5.	17-34-119-005-0000	NURSING HOME	$ 8,979.26	$ 8,979.26
6.	17-34-119-006-0000	NURSING HOME	$ 8,979.26	$ 8,979.26
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 159,502.01	$ 159,502.01

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,000	1995	$ 100,000	1
2					2
3	TOTALS	51,000		$ 100,000	3

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1995	1971	$ 4,046,250	$ 103,746	39	$ 103,746	$	$ 817,141	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LIGHT FIXTURES			1987	3,077		20	154	154	2,393	9
10	LEASEHOLD IMPROVEMENTS			1987	1,159	37	15	77	40	1,125	10
11	FIRE ALARM SERVICE			1988	10,046	319	20	502	183	7,404	11
12	ROOFING			1989	2,000	64	20	100	36	1,442	12
13	SEWER REPAIR			1989	3,250	217	15	217		2,839	13
14	ROOFING & AWNING			1990	7,780	247	20	389	142	4,960	14
15	LEASEHOLD IMPROVEMENTS			1991	16,578	575	20	829	254	9,493	15
16	LEASEHOLD IMPROVEMENTS			1992	1,800	120	15	120		1,260	16
17	LEASEHOLD IMPROVEMENTS			1992	19,702	625	31.5	625		6,558	17
18	LEASEHOLD IMPROVEMENTS			1993	25,871	736	31.5	821	85	7,715	18
19	LEASEHOLD IMPROVEMENTS			1994	8,666	222	39	222		1,795	19
20	LEASEHOLD IMPROVEMENTS			1994	4,690		20	235	235	1,997	20
21	ROOF REPAIRS			1995	1,500	38	39	38		300	21
22	ELEVATOR REPAIR / DOOR			1995	5,575	143	39	143		1,007	22
23	LANDSCAPING / FENCE REPAIR			1995	5,195	347	15	347		2,602	23
24	SUMP PUMP			1996	2,840	73	39	73		490	24
25	WALK-IN FREEZER REPAIR			1996	3,187	81	39	81		537	25
26	ROOF REPAIRS			1996	8,735	224	39	224		1,428	26
27	SECURITY SYSTEM			1996	1,035	27	39	27		163	27
28	ELEVATOR REPAIR			1997	6,017	154	39	154		877	28
29	WINDOWS			1997	1,170	30	39	30		169	29
30	CARPETING			1998	2,187	56	39	56		264	30
31	FIRE DAMPERS			1998	8,240	211	39	211		879	31
32	SEWER REPAIRS			1998	2,704	69	39	69		290	32
33	IRON FENCE			1998	4,684	312	15	312		1,404	33
34	INSTALL PIPE			1999	6,043	155	39	155		588	34
35	FLOORING-RESIDENT BATHROOMS			2000	23,773	864	27.5	864		2,412	35
36	ALARM SYSTEM			2000	94,362	3,431	27.5	3,431		9,579	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SMALL SERVICE ELEVATOR	2000	$ 64,585	$ 2,348	27.5	$ 2,348	$	$ 4,990	37
38	AWNING	2000	2,700	98	27.5	98		208	38
39	INSTALL NEW ROOF SYSTEM	2000	49,600	1,803	27.5	1,803		3,832	39
40	REPAIR SMALL & LARGE PASSENGER ELEVATORS	2001	5,786	210	27.5	210		377	40
41	INSTALL NEW STEAM TABLE	2001	4,147	151	27.5	151		270	41
42	EJECTOR PUMP	2001	2,878	105	27.5	105		179	42
43	INTERIOR ENTRANCE-INSTALL ALUMINUM DOOR	2001	2,748	100	27.5	100		154	43
44	RESIDENT ROOMS-CLOSETS	2001	20,078	730	27.5	730		1,065	44
45	EXISTING SPRINKLER SYSTEM-PLACARD	2001	3,600	131	27.5	131		180	45
46	INSTALL CHAIN FENCE	2001	1,400	133	15	133		226	46
47	FIRE ALARM REPAIR	2001	6,392	232	27.5	232		280	47
48	REPLACEMENT CARPET FOR 5 OFFICES	2001	3,294	1,054	20	165	(889)	330	48
49	REPLACEMENT OF WINDOW	2001	2,880	105	27.5	105		118	49
50	INSTALL BASEBOARD COVERS, WALK-IN COOLER	2001	3,314	1,060	20	166	(894)	332	50
51	NEW WALL, FLOORING-ELEVATORS	2001	4,506	1,442	20	225	(1,217)	450	51
52	FLOORING-1ST, 2ND, 3RD FL CORR/DAYROOM/NURSES ST	2002	49,673	1,588	27.5	1,588		1,588	52
53	NEW WINDOW TREATMENTS, DRAPERY PANELS	2002	6,807	2,995	20	340	(2,655)	340	53
54	2ND & 3RD FLOOR-WOOD BASEBOARD	2002	3,367	1,481	20	168	(1,313)	168	54
55	WALLCOVERING-LOBBY 1ST, 2ND & 3RD FLOOR	2002	31,043	329	27.5	329		329	55
56	INSTALL NEW SUSPENDED CEILING & LIGHTING	2002	46,843	213	27.5	213		213	56
57	ELECTRICAL WORK-1ST, 2ND AND 3RD FLOOR	2002	9,105	14	27.5	14		14	57
58									58
59									59
60									60
61	CAREPLUS MGMT INC: LEASEHOLD IMPROVEMENTS			104		104			61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,652,862	$ 129,549		$ 123,710	$ (5,839)	$ 904,754	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 169,854	$ 24,106	$ 16,323	$ (7,783)	3-15	$ 78,682	71
72	Current Year Purchases	30,643	13,484	1,651	(11,833)	8-10	1,651	72
73	Fully Depreciated Assets	77,769					77,769	73
74	RELATED PARTY ALLOC SL DEPR		20,817	20,817				74
75	TOTALS	$ 278,266	$ 58,407	$ 38,791	$ (19,616)		$ 158,102	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,031,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 187,956	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 162,501	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (25,455)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,062,856	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 28,237 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 21,677	$		$ 21,677	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			62,330			62,330	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				34,890		34,890	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LABORATORY	39-2 39-2					240 746		240 746	13
14	TOTAL			$		$ 84,007	$ 35,876		$ 119,883	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 55,092	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	2,482,113		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,756		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	119,556		8
9	Other(specify): Real Estate Tax Escrow	455,387		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,187,904	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	598,845		15
16	Equipment, at Historical Cost	286,033		16
17	Accumulated Depreciation (book methods)	(319,954)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(29,387)		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 535,537	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,723,441	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 427,123	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,904		28
29	Short-Term Notes Payable	1,886,921		29
30	Accrued Salaries Payable	93,399		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,126		31
32	Accrued Real Estate Taxes(Sch.IX-B)	161,097		32
33	Accrued Interest Payable	11,898		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,617,468	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,617,468	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,105,973	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,723,441	$	48

***(See instructions.)**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 904,682	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(110,000)	3
4	ROUNDING	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 794,685	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	311,288	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 311,288	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,105,973	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,079,756	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,079,756	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	5,557	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,557	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,800	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,800	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,087,115	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	787,135	31
32	Health Care	1,590,993	32
33	General Administration	1,258,382	33
	B. Capital Expense		
34	Ownership	934,070	34
	C. Ancillary Expense		
35	Special Cost Centers	119,883	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,775,326	40
41	**Income before Income Taxes (line 30 minus line 40)****	311,789	41
42	**Income Taxes**	(501)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 311,288	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** **TAX RETURN CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,949	1,997	$ 55,955	$ 28.02	1
2	Assistant Director of Nursing	1,774	2,054	48,730	23.72	2
3	Registered Nurses	2,457	2,555	56,727	22.20	3
4	Licensed Practical Nurses	28,962	30,061	554,802	18.46	4
5	Nurse Aides & Orderlies	62,027	66,426	557,179	8.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,472	6,316	54,967	8.70	8
9	Activity Director	1,322	1,348	18,217	13.51	9
10	Activity Assistants	6,784	7,195	47,314	6.58	10
11	Social Service Workers	4,286	4,678	71,535	15.29	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,167	29,816	13.76	13
14	Head Cook	5,201	5,548	41,134	7.41	14
15	Cook Helpers/Assistants	11,011	11,880	75,370	6.34	15
16	Dishwashers					16
17	Maintenance Workers	3,860	4,095	40,546	9.90	17
18	Housekeepers	16,244	17,494	119,705	6.84	18
19	Laundry	6,457	6,999	54,430	7.78	19
20	Administrator	4,145	4,507	120,841	26.81	20
21	Assistant Administrator	442	451	9,336	20.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,561	8,014	97,436	12.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,968	2,057	19,161	9.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,959	185,842	$ 2,073,201 *	$ 11.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,600	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	2,112	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	480	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,024	11-3	44
45	Social Service Consultant	E	2,956	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,972		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides		N/A	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEVIN MEALS	ADMIN	0	$ 58,528
CYNTIA STAIN	ADMIN	0	62,313
	ASST ADMIN	0	9,336
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 130,177

B. Administrative - Other

Description		Amount
CAREPLUS MGMT, INC.	MANAGEMENT FEE	$ 144,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 144,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		226,267
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 226,267

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,203
Unemployment Compensation Insurance	28,833
FICA Taxes	156,662
Employee Health Insurance	105,577
Employee Meals	16,754
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,688
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	18,631
CHICAGO HEAD TAX	4,032
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 365,380

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,007
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,980
TRUST/FRANCHISE/CONTRIB/ETC	400
LICENSES & PERMITS	1,887
DUES & SUBSCRIPTIONS	10,469
MGMT CO ALLOCATION	2,586
TRUST/FRANCHISE/CONTRIB/ETC	(400)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,980)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,149

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	420
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 420

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	2001	$ 1,552	3 YRS	$	$	$ 258	$ 518	$ 518	$ 258	$	$	$
2	PAINTING/DECORATIN	2002	2,039	3 YRS				340	680	680	340		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,591		$	$	$ 258	$ 858	$ 1,198	$ 938	$ 340	$	$

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8370**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **84,863**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **16,754** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BOULEVARD CARE CENTER **#0032276** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,600	
	REPAIRS & MAINTENANCE		3,103	
			0	9,703
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		31,811	
	ELECTRICITY		49,001	
	WATER		25,563	
	CABLE TV - LOBBY		1,337	
			0	107,712
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,964	
	PAINTING & DECORATING		2,039	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		11,477	
	ELEVATOR MAINTENANCE & REPAIR		7,085	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,420	
	FIRE SERVICE		9,086	
			0	
			0	
			0	38,071
7	**OTHER**			
	SCAVENGER		12,899	
	SECURITY SERVICE		0	12,899
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,112	
	PHARMACY CONSULTANT	XVIII B 39-2	480	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	2,592
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		14,918	
	THERAPY CONTRACT SERVICES		10,246	
	OCCUPATIONAL THERAPY SERVICES		8,357	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	44,321
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,024	
			0	2,024
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,956	
			0	2,956
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BOULEVARD CARE CENTER **#0032276** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	144,000	144,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	16,591	
	ADMINISTRATIVE CONSULTANTS	XIX C	168,000	
	PROFESSIONAL FEES	XIX C	41,676	
			0	226,267
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,980	
	EMPLOYEE WANT ADS	XIX F	2,007	
	CONTRIBUTIONS	VI 20 XIX F	400	
	DUES & SUBSCRIPTIONS	XIX F	10,469	
	LICENSES & PERMITS	XIX F	2,087	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	16,943
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)			
	EQUIPMENT REPAIR & MAINTENANCE		11,930	
	OUTSIDE CLERICAL SERVICES		93,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	32,297	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,218	
	MESSENGER SERVICE		1,927	
			0	160,372

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	156,662	
	UNEMPLOYMENT COMPENSATION	XIX D	28,833	
	WORKERS COMPENSATION INSURANC	XIX D	33,203	
	HOSPITALIZATION INSURANCE	XIX D	105,577	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,688	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	UNION PENSION FUND/401 K EXPENSE	XIX D	18,631	
	CHICAGO HEAD TAX	XIX D	4,032	348,626
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		740	740
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		86	86
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		122,737	122,737
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,240,049

BOULEVARD CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	174,717
LESS SALES TAX	(310)
NET FOOD	174,407
TOTAL PATIENT CENSUS	51,397
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	154191
ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	16425

PATIENT MEALS	154191
ADD EMPLOYEE MEALS	16425
TOTAL MEALS/YEAR	170616
NET FOOD	174407
DIVIDE TOTAL MEALS/YEAR	170616
COST PER MEAL	1.02
TIME EMPLOYEE MEALS	16425
EMPLOYEE MEAL RECLASSIFICATION	16754